The SPEAKER pro tempore (Mr. ROGERS). Under a previous order of the House, the gentlewoman from Connecticut [Ms. DELAURO] is recognized for 5 minutes.

[Ms. DELAURO. addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington [Mr. METCALF] is recognized for 5 minutes.

[Mr. METCALF addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from North Carolina [Mrs. CLAYTON] is recognized for 5 minutes.

[Mrs. CLAYTON addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana [Mr. ROEMER] is recognized for 5 minutes.

[Mr. ROEMER addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

PROGRESS REPORT ON WOMEN'S HEALTH

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentlewoman from Maryland [Mrs. MORELLA] is recognized for 60 minutes as the designee of the majority leader.

Mrs. MORELLA. Mr. Speaker, I am really very pleased to sponsor tonight's special order on women's health with my colleagues NANCY JOHNSON, LOUISE SLAUGHTER, and ELEANOR HOLMES NORTON, and so many of our colleagues who are here this evening.

The Congressional Caucus for Women's Issues has spent a number of years attempting to address the neglected women's health research at the National Institutes of Health. The caucus asked the General Accounting Office in 1989 to investigate the NIH policy regarding the inclusion of women in clinical studies.

Women had been routinely excluded from many studies, such as the Physicians' Health Study which studied the effects of aspirin on heart disease of 22,000 male physicians. Another study, the Multiple Risk Factor Inventory Trial, a 15-year project studying the risk factors for cardiovascular disease, included 13,000 men and no women.

In 1990, the GAO reported that the NIH had made quote, little progress in implementing a 4-year-old policy to encourage the inclusion of women in research study populations. The caucus in 1990 introduced omnibus legislation, the Women's Health Equity Act, which included the establishment of an Office of Research on Women's Health and the requirement that women and minorities be included wherever appropriate in research studies funded by NIH.

Well, in the fall of 1990, at a meeting with many caucus members, NIH announced the formation of the Office of Research on Women's Health, to ensure that greater resources were devoted to diseases primarily affecting women and to ensure that women were included in clinical trials. Since 1990, great progress has been made in funding for women's health concerns, particularly breast, ovarian, and cervical cancer, osteoporosis, and the women's health initiative.

While I focus my remarks tonight on HIV AIDS, osteoporosis, and domestic violence, there are so many issues critical to women's health that will not be mentioned tonight but are still high priorities for all of us.

Since 1990 I have been the sponsor of legislation to address women and AIDS issues. Women are the fastest growing group of people with HIV, and AIDS is the third leading cause of death in women ages 25 to 44. While the overall number of AIDS deaths declined last year, the death rate for women actually increased by 3 percent, resulting in a record 20 percent of reported AIDS cases in adults.

Low-income women and women of color are being hit the hardest by this epidemic. African-American and Latino women represent 75 percent of all U.S. women diagnosed with AIDS.

NIH is currently working to develop a microbicide. This is a chemical method of protection against HIV and STD infection, which is sexually transmitted disease infection, with an emphasis on methods that women can afford, control without the cooperation and knowledge of their male partners, and use without excessive difficulty.

We must acknowledge the issues of low self-esteem, economic dependency, fear of domestic violence, and other factors which are barriers to empowering women to negotiate safer sex practices. Research on a safe and effective microbicide must be a priority for our research and prevention agendas, and we must also work to answer the full range of questions important to understanding HIV in women, including adequate funding for the women's interagency HIV study, the natural history study of HIV in women.

In order to address these priorities for women, I will be introducing my women and AIDS research bill next week, and I hope my colleagues here tonight will join me as original cosponsors.

The gentlewoman from California [Ms. PELOSI] and I have also introduced H.R. 1219, a comprehensive HIV prevention bill which includes the provisions of my bill from the last Congress to address the need for more targeted prevention programs for women. Our bill authorizes funding for family planning providers, community health centers, substance abuse treatment programs, and other providers who already serve low-income women to provide community-based HIV programs. Our bill also creates a new program to address concerns about HIV for rape victims.

In my work focusing on the needs of women in the HIV epidemic, the effectiveness of community-based prevention programs has been demonstrated time and time again. Providers with a history of service to women's communities understand that prevention efforts must acknowledge and respond to the issues of low self-esteem, economic dependency, fear of domestic violence, and other factors which are barriers to empowering women. I urge my colleagues to cosponsor this legislation.

Now on to osteoporosis. Mr. Speaker, it is a major public health threat for 28 million Americans who either have or are at risk for the disease. One out of every 2 women and 1 in 8 men over age 50 will have an osteoporosis-related fracture.

A woman's risk of hip fracture is equal to her combined risk of breast, uterine, and ovarian cancer. Often a hip fracture marks the end of independent living. Many enter nursing homes and a large percentage die within 1 year following the fracture. The costs incurred due to the 1.5 million annual fractures are staggering at $13.8 billion, or $38 million a day. Osteoporotic fractures cost the Medicare Program 3 percent of its overall cost.

I have reintroduced H.R. 1002 along with the gentlewoman from Connecticut, [Mrs. JOHNSON], the gentlewoman from New York, [Mrs. LOWEY] and the gentlewoman from Texas, [Ms. EDDIE BERNICE JOHNSON], to standardize Medicare coverage for bone mass measurement tests for the diagnosis of osteoporosis. Without bone density tests, up to 40 percent of women with low bone mass could be missed at a time when we now have drugs that promise to reduce fractures by 50 percent.

At this time, Medicare leaves the decision to cover bone density tests to local Medicare insurance carriers, and the definition of who is qualified to receive a bone mass measurement varies from carrier to carrier. H.R. 1002 would standardize Medicare coverage in order to avoid some of the 1.5 million fractures caused annually by osteoporosis. Since these tests are already covered by every carrier, the cost to the Medicare Program will not be substantial. As a matter of fact, with Congresswoman JOHNSON, we just met with representatives of the Congressional Budget Office to talk about that.

With regard to domestic violence, we have made great progress, yes, in training law enforcement personnel about domestic violence and funding battered women's shelters and starting up the national domestic violence hotline. I want to say that our speaker this evening has been certainly very cooperative and generous in the funding of the Violence Against Women Act.

But one area where we have room for improvement is in the training of our